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310 - LEAD CARE COORDINATOR

NOTE: The lead care coordinator may be employed by the AAA or the Care Coordination Agency that subcontracts with the AAA.

Qualifications:

- If applicant is a nurse, all qualifications reflected in the CCSP care coordination team nurse job descriptions and a current license to practice in the State of Georgia.
- If applicant is not a nurse, all qualifications reflected in the CCSP care coordinator (social services) job description, and one year experience as a CCSP social services care coordinator and a bachelor's degree in a social service field.

General Description:

- Supervises care coordination personnel and/or acts as the liaison between care coordination and the Executive Director of the subcontract agency, or the lead agency.

Supervisory duties:

- Interprets policy and procedure.
- Provides initial training and orientation to new care coordination personnel.
- Provides or arranges in-service training for care coordination personnel.
- Represents care coordination at network meetings and other interagency meetings as directed by the Executive director of the subcontract agency or the lead agency.
- Serves as the contact person for lead agency staff, providers, care coordination and Division of Aging Services at the direction of the lead agency.
- Assures that case files and care coordinators' performance are reviewed as needed, or at a minimum that monthly supervisory staff conferences are held.
- Monitors performance and prepares annual written performance evaluations of care coordination staff for the Executive Director of the subcontract agency or the lead agency.
- Arranges and participates in case conferences.
- Maintains current and appropriate personnel/training records.

Public Relations Duties:

- Provides support to lead agency in an assigned geographical area to educate the general public, health and social service agencies, physicians and other health professionals, nursing homes, hospitals, health providers, church and civic groups, etc., regarding the services available, and establishes credibility within the community.

Administrative Duties:

- Assures that statistical data is compiled and submitted on a regular basis in conjunction with care coordination team members.
- Assists in development and revision of policies and procedures.
- Attends organizational meetings and training as required.
- Keeps lead agency/subcontractor agency supervisor informed of CCSP progress and problems.

Other Duties:

- Attends hearings as requested, providing data and client records required by the hearing officer.
- Collaborates with social services care coordinators in development of the Comprehensive Care Plan.
- Refers protective services clients who are not eligible for mandatory assessment to DFCS social services units if they are not in a PCH. If they are in a PCH, refers to LTCO and ORS.
- Refers clients not appropriate for CCSP assessment to other services.
- Refers clients on the waiting list to other community resources for assistance.
- May or may not maintain a caseload according to agency policy/practice. If client caseload is maintained refer to appropriate job description based on qualifications.
- Maintains an updated Care Coordination Manual and Provider Services Manual.
- Consults with AAA, and/or DAS with approval of AAA, regarding policy interpretation, admitting clients when program is full, difficult cases, DMA-80 requests, and client referrals made by DAS or DHR Commissioner's office.

320 - CARE COORDINATION REGISTERED NURSE

NOTE: Employed by the AAA or care coordination subcontract agency.

Qualifications:

Two years experience as a registered professional nurse in one of the following areas:

- Geriatric nursing
- Community health
- Long term care
- Chronic diseases of adults.

NOTE: Completion of a course of study equivalent to a Master's degree in nursing, or community health may substitute for one year of experience.

General Description:

- Under direction, performs work of considerable difficulty in the professional assessment and determination of a level of care and appropriateness for community-based services for Medicaid recipients or potential Medical Assistance Only clients. Functions as a member of an interdisciplinary team including a physician and serves large geographic areas which may include parts of one large county and/or many small counties which involve extensive travel. May supervise care coordination team care coordinators at direction of lead care coordinator or agency policy.

Supervisory duties as appropriate:

Refer to care coordinator supervisory duties/Administrative under lead care coordinator job description.

Referral and screening duties as appropriate, according to AAA care coordination model:

1. Receives and screens both emergency and non-emergency referrals.
2. Documents all potential referrals on screening/assessment instrument.
3. Reviews initial financial, medical, and social information of potential client as presented by referral source or the applicant.
4. Verifies Medicaid eligibility and/or screens for MAO/PMAO eligibility for using a standardized guideline.
5. Explains thoroughly the scope and purpose of CCSP.
6. Identifies client's needs and desired services as stated by referral source or the applicant.

7. Determines that client is ineligible or inappropriate for a level of care and CCSP placement and refers client to other appropriate resources.
8. Determines that client is eligible and appropriate for level of care and CCSP placement and refers client for full assessment. If program is full places client on waiting list.

Assessment/Reassessment Duties:

1. Schedules appointment for face-to-face interview with prospective client at client's residence, hospital, long-term care facility, or other appropriate site as indicated.;
2. Conducts comprehensive interview with client and/or representative using standardized level of care and MDS-HC that allows for compilation of pertinent social information, functional status, physical, mental, nutritional status, adequacy/inadequacy of support system, and physical environment as well as the client's preference for community-based or institutional services.
3. Explains to client and/or representative all aspects of the program and obtains client signature on all necessary forms.
4. Analyzes and interprets all medical, social information as compiled, and obtains additional information as needed; e.g. consultation with physician and other professionals.
5. Uses a comprehensive approach, to discuss and clarify client's needs in an interdisciplinary team meeting.
6. Determines with care coordinator appropriate service and service setting necessary to maintain or improve the health/functional status of clients.
7. Determines a level of care for CCSP or makes a recommendation for institutional care.
8. Develops with care coordinator an initial care plan.
9. Completes a reassessment on clients following the appropriate guidelines.

Public Relations Duties:

- Assists lead agency in an assigned geographical area to educate the general public, health and social service agencies, physicians and other health professionals, nursing homes, hospitals, health providers, church and civic groups, etc., regarding the services available.

Administrative Duties:

- Assists with statistical data compilation.
- Assists in development and revision of policies and procedures.
- Attends organizational meetings and training as required.
- Keeps supervisor informed of CCSP progress and problems.

Other Duties:

- Attends CCSP network meetings.
- Attends hearings as requested, providing data and client records required by the hearing officer.
- Collaborates with social services care coordinators in development of the Comprehensive Care Plan.
- Refers protective services clients who are not eligible for mandatory assessment to DFCS social services units if they are not in a PCH. If they are in a PCH, refer to LTCO and ORS.
- Refers to other services all clients not appropriate for CCSP assessment.
- Refers clients on the waiting list to other community resources for assistance.
- May maintain a caseload according to agency policy/practice.
- Maintains an updated Care Coordination Manual and Provider Services Manual.

330 - CARE COORDINATION SOCIAL SERVICES WORKER

NOTE: Employed by the AAA or Care Coordination subcontract Agency.

Qualifications:**A. Minimum Education and Experience**

- Bachelor's degree in social work, sociology, psychology, or a related field, OR
- Registered, professional nurse currently licensed to practice in the State of Georgia
- Two years experience in the human service or health related field.

B. Minimum Skill and Knowledge

- Ability to effectively coordinate and communicate with clients, service providers, general public, and other staff members
- Skill in establishing and sustaining interpersonal relationships
- Knowledge of human behavior, gerontology
- Skills in team building and group dynamics
- Knowledge of community organization and service system development
- Problem solving skills and techniques
- Knowledge and skill in social and health service intervention techniques and methodology.

General Description:

- Under direction, performs work of moderate difficulty by providing skilled casework services to selected caseloads or clients with special problems such as health disability or those at risk of nursing home placement; provides specialized casework services aimed at securing the client's overall well being and maximum degree of independent functioning. Serves large geographic areas which may include one large county and/or many small counties which may involve extensive travel, and performs related work as required.

Social services care coordinator's duties include the following:

NOTE: Lead Agencies may expand this list as appropriate based on local identified needs.

Referral/Screening Duties (determined by AAA and/or model):

1. Receives and screens both emergency and non-emergency referrals.
2. Documents all potential referrals on Telephone Screening (TS).
3. Reviews initial, financial, medical, and social information of potential client as presented by referral source.
4. Verifies Medicaid eligibility and/or screens for MAO/PMAO eligibility, using standardized guidelines.
5. Explains thoroughly the scope and purpose of the CCSP.
6. Identifies client's needs and desired services as stated by the referral source or applicant.
7. Determines that client is ineligible/inappropriate for level of care and CCSP placement and refers client to other appropriate resources.
8. Determines that client is eligible/appropriate for level of care and CCSP placement and refers client for full assessment. If program is "full" places client on waiting list.

Social Services Duties:

- Researches and maintains up-to-date knowledge of community resources.
- Participates in case conferences with the RN team to discuss the plan of care as needed. Provides information on the availability of services, delivery options, and on the feasibility of implementing the service needs identified by the RN. In cooperation with the RN, determines the cost for implementing the plan of care for the client.
- Develops the 30 day comprehensive care plan in consultation with the client, client's family and service providers.
- Serves as the liaison between the assessment process and the effective delivery of direct services.
- Brokers the CCSP services and implements the care plan.
- Arranges for non-CCSP community-based services needed by the client.
- Monitors service delivery to individual clients to assure services are being provided as appropriate and effectively meets the client's needs.
- Continuously reviews, monitors, and updates the comprehensive care plan.

- Documents case activity and service information.
- Communicates and coordinates with all agencies providing direct services to the client.
- Approves/disapproves providers' requests for increased services. Limits amount and frequency of service in order to assure that costs do not exceed the limitations established by the Division of Aging Services and the Department of Medical Assistance.
- Conducts personal contacts with each client as needed/ or at a minimum quarterly in order to provide effective care coordination. Completes the CCP Review Guide.
- Reports suspected abuse, neglect, or exploitation of any client to APS if client does not live in a PCH, or to LTCO and ORS if client lives in a PCH. Reports information to the ALS family model provider, if appropriate.
- Arranges emergency services.
- Completes the Service Authorization Form (SAF). Deauthorizes unused services.
- Monitors the expenditure of funds for Title XIX waived services in the planning and service area, in cooperation with the lead agency.
- Completes the DMA-80 and PAR when applicable.
- Communicates with DFCS regarding MAO/PMAO eligibility.
- Maintains confidential case records on all CCSP clients.
- Requests redetermination of the client's level of care prior to its expiration.
- Arranges for reassessments by the care coordinator RN as appropriate.
- Advocates for the special needs of the functionally impaired population requiring community based services.
- Maintains knowledge of the provider service standards for each CCSP service.
- Assists clients with appeals and attends hearings. As requested, provides data and client records required by hearing officer.
- Attends CCSP Network meetings and other meetings coordinated by AAA.

Reassessment Duties, as appropriate:

- Schedules appointment for face-to-face interview with prospective client at client's residence, hospital, long-term care facility, or other appropriate site as indicated.
- Conducts comprehensive review with client and/or representative using the Form 5588.
- Assures that client/representative understands all aspects of the program and obtains client signature on all necessary forms.
- Analyzes and interprets social information as compiled.
- Collaborates with care coordinator RN and client's physician to define appropriate services and service setting necessary to maintain or improve the health/functional status of client.
- Develops with the RN the initial care plan.
- Completes a full reassessment on those clients where there is no significant change in functional status.

Public Relations Duties:

- Provides support to the lead agency in an assigned geographical area to educate the general public, health and social service agencies, physicians and other health professionals, nursing homes, hospitals, health providers, church and civic groups, etc., regarding the services available.

Administrative Duties:

- Meets with supervisor at least monthly to discuss and review cases.
- Compiles and submits to supervisor statistical data on a regular basis.
- Assists in development and revision of policies and procedures.
- Attends organizational meetings, and training as required.
- Keeps supervisor informed of progress and problems associated with duties.
- Maintains an up to date Care Coordination Manual and Provider Services Manual.
- Performs other duties as assigned.

340 - CCSP SCREENING SPECIALIST

NOTE: The CCSP screening specialist may be employed by the AAA or the care coordination agency that subcontracts with the AAA.

Qualifications:

- If an applicant is a nurse, all qualifications reflected in the CCSP care coordination team nurse job descriptions and a current license to practice in the State of Georgia.
- If an applicant is not a nurse, all qualifications reflected in the CCSP care coordinator (social services) job description, and one year experience as a CCSP social services care coordinator and a bachelor's degree in a social service field.

NOTE: If the care coordination agency/AAA has more than one screening specialist position, DAS recommends that the employer hire a registered nurse and a social services worker.

General Description:

Acts as first point of contact for individuals requesting services from the CCSP, either for themselves or someone else.

Screening Duties:

- Screens referrals within three business days of receipt.
- Accepts and screens telephone referrals from individuals wishing to participate in the CCSP.
- Conducts a telephone screening, completes the TSI, and determines applicant priority for full assessment.
- Determines Medicaid status.
- Identifies applicant needs and service requests as stated by referral source.
- Notifies the potential applicant/referral source of referral status.
- Informs ineligible applicants of the right to appeal.
- When appropriate, refers applicant for other needed services.